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Connecticut General Assembly – Insurance and Real Estate Committee
Public Hearing – March 15, 2022
HB 5383

Testimony of Laura Hoch,
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Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock-D'Amato and members of the Insurance and Real Estate Committee, thank you for the opportunity to submit testimony on HB 5383, An Act Concerning Association Health Plans, and how it may impact individuals living with multiple sclerosis (MS).

The National Multiple Sclerosis Society (the Society) urges this committee *not* to pass HB 5383 and instead to focus its efforts on protecting people living with chronic illnesses or disabilities to ensure their continued access to more affordable, adequate, and understandable health care coverage. Like all organizations representing the interests of people with special health needs, we have a unique perspective on what individuals and families need to manage their conditions and live their best lives.

MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling to walking difficulties, fatigue, dizziness, pain, depression, blindness, and paralysis. The progress, severity, and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. Nearly 1 million people in the United States are currently living with MS. Most people with MS are diagnosed between the ages of 20 and 50, with at least two to three times more women than men being diagnosed with the disease.

We are deeply concerned about the impact that Association Health Plans (AHPs) will have on individuals living with MS and their families. While AHPs can offer less costly coverage, they frequently do not adhere to important standards, including financial protections and coverage for essential health benefits. AHPs also have a long history of fraud and insolvency which have historically harmed small employers and individuals the most. Many of these plans collected premiums for health insurance coverage that did not exist and did not pay medical claims -- leaving businesses, individuals, and providers with millions of dollars in unpaid bills. For consumers and patients, the results were disastrous. We are extremely concerned that allowing AHPs in Connecticut will once again leave families in the lurch with insufficient coverage,

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unpaid medical bills, and lifelong health implications – just as many of these plans did before the Affordable Care Act (ACA) was passed.

Adequacy

Healthcare coverage for people with MS must be adequate, covering the comprehensive package of services and treatments they need to live their best lives. It is paramount that protections including EHB packages, the ban on annual and lifetime caps, and restrictions on premium rating all be preserved. We are deeply concerned that AHPs could offer entirely inadequate, even discriminatory, coverage. We are also concerned that these plans will further confusion for consumer looking for coverage.

Essential Health Benefits (EHBs)

One of the most troubling aspects of Association Health Plans is that they are not required to comply with EHB coverage requirements created under the ACA. This is deeply concerning because those individuals we represent rely on the current law's coverage requirements for access to medically necessary care. Prior to the passage of the ACA and creation of the ten EHB categories, people with MS routinely found themselves enrolled in plans that failed to provide coverage for the complex health care needs that MS demands. We often heard from individuals and families upon discovering that they were not covered for such essential components of quality MS care as specialty pharmaceuticals, neurology care, rehabilitation therapies, MRIs, or durable medical equipment.

Discriminatory Plan Design

AHPs can offer differing coverage to groups of enrollees based on non-health related factors. These factors could include gender, age, employee classifications, locations, or any other non-health criteria that could stratify the plan's beneficiary population. Therefore, AHPs could structure their coverage and benefit designs using "non-health related factors" to effectively exclude entirely classes of beneficiaries with higher rates of illness and disease.

Furthermore, even if AHPs chose to offer uniform coverage to all beneficiaries regardless of any non-health related factor, they could still freely structure their benefit design in any way they saw fit. This allowance would once again enable discriminatory plan designs that exclude benefits for enrollees with certain health and preexisting conditions, including MS.

Consequently, AHPs could design a plan that excludes coverage for medically necessary prescription drugs, certain specialists who treat particularly expensive conditions, or other medically necessary care for individuals with chronic conditions. According to the Kaiser Family Foundation, approximately 27 percent of American adults currently have a condition that

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would result in being denied health coverage.[1] Employees or their dependents could once again face these same coverage denials within AHPs, resulting in entirely inadequate coverage.

This allowance for discriminatory benefit design completely undermines the guaranteed issue requirement by enabling AHPs to de facto deny coverage to individuals with pre-existing conditions by creating "non-health" classifications with substantially weaker coverage, or by refusing to offer coverage for the specific care they need.

Network Adequacy

AHPs are also exempt from any ACA-related network adequacy requirements. While ACA-compliant Qualified Health Plans (QHPs) must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, neurology, maternity and newborn care, mental health, and emergency services, AHPs are not required to comply with these standards.

This is particularly concerning for us as we represent the individuals who are most in need of access to prescription drugs, rehabilitation and other outpatient care, and specialty physicians. These providers and health services are also often the most expensive. Without regulation and oversight of network adequacy within AHPs, the physicians and services patients rely on could be excluded from AHP provider networks altogether. For example, AHPs may choose to exclude all MS Centers, neurologists, or ophthalmologists from their provider networks. They may also include facilities or specialists in the network that are far too distant, or inaccessible.

Consumer Education and Transparency

As advocates for a population of patients with lifelong, high-cost health care needs, we are concerned that employers and prospective enrollees of AHPs will not be sufficiently informed about these products prior to enrollment. Our experience prior to passage of the ACA suggests that many (if not most) were confused about what a health insurance policy would and would not cover due to a lack of required transparency, resulting in cases of medical debt and bankruptcy. Patients were also forced in some cases to delay or forgo treatment. We fear a dramatic increase in these outcomes if AHPs are made easily available to consumers without clear transparency about what they do, and do not, cover.

[1]Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, and Karen Pollitz, "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Found. Issue Brief, Dec. 12, 2016, available at https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

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Survey data, focus group testing, and academic research on Americans' understanding of health insurance reveals serious deficiencies in comprehension of the common language and concepts of health insurance. Research has highlighted evidence of Americans' health and health insurance literacy including: nearly nine out of ten adults had difficulty using health information to make informed decisions about their health[2]; 51 percent of respondents did not understand the basic health insurance terms premium, deductible and copay; and only 16 percent could calculate the cost of an out-of-network lab test.[3] Consumers Union has cautioned that it is not enough to know the difference between premiums, deductibles, and copays, one must also understand how these costs must be sequenced to understand how health insurance works in the context of real world health care needs.[4]

We note that the ACA sought to address many of these concerns by implementing new measures to educate people about health insurance, including the online Marketplaces, the Summary of Benefits & Coverage, Glossary of Health Care Terms, disclosure of Actuarial Value, and for some, access to new professional insurance counselors with no vested interest in consumers' choice of health plan. These resources are helping consumers make more informed choices by presenting and explaining details about coverage, costs, and plan policies. Yet because most of these helpful tools would not be required resources of AHPs, prospective enrollees of AHPs would not benefit from them, improvements in health care and health insurance literacy could be reversed, and more Americans would be at risk of being under-insured once more. This lack of transparency is particularly concerning as it relates to AHPs because of their history of fraud and insolvency. Consumers have grown accustomed to and expect health insurance to be comprehensive and may not even realize these plans do not meet those same standards.

Affordability

Having access to treatments also means they should be affordable, including reasonable premiums and cost-sharing, with protections for individuals with pre-existing conditions from being charged more for their coverage. We are concerned that AHPs in Connecticut would fail to achieve this aim.

<u>Lifetime and Annual Caps</u>

[2] http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf
[3] Ibid.
[4] Ibid.

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Under current law, the ban on lifetime and annual caps only applies to EHB-covered services. AHPs do not have to comply with EHB coverage requirements. Therefore, this legislation would potentially subject patients to significant financial insecurity due to medical needs. In 2007 alone, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.[5] Patients who faced heart transplants, used specialty medications (such as those to treat MS), had complicated pregnancies, a cancer diagnosis, or other rare and complex conditions could easily meet or exceed lifetime and annual caps. For example, prior to the ACA, many children with hemophilia would hit the lifetime limit on coverage under both parents' insurance plans before their 18th birthday, leaving them without coverage options.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for QHPs to include an annual out-of-pocket maximum set each year by the Department of Health and Human Services (HHS). For 2017, the annual out-of-pocket limit for an individual was $7,350, and for a family plan was $14,700.[6] Similar to the ban on annual and lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. AHPs subject patients with complex and chronic conditions to unaffordable cost-sharing for the medically necessary services upon which they rely.

Accessibility

The Society firmly believes that coverage and care must be accessible. Everyone needs access to quality and affordable healthcare to manage their health. The connection between access to health insurance and health outcomes is clear and well documented.[7,8]

Market Segmentation

We are concerned about the impact of the proliferation of AHPs on the individual market overall stability. We expect that individuals with serious and chronic conditions will continue to enroll in coverage offered through the state marketplace. Conversely, younger and healthier individuals may be more likely to shop for coverage based on premiums and thus may be more

[5] Himmelstein DU, Throne D, Warren E, Woolhander S, Medical bankruptcy in the United States, 2007: results of a national study. Am J Med 2009 Aug; 122(8): 741-6. Doi.

[6] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Final Rule, 81 Fed. Reg. 94058 (Dec. 22, 2016).

[7] Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

[8] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

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drawn to lower cost AHPs, even though these products will likely have less comprehensive coverage.

Over time, as younger and healthier individuals leave the marketplace, premiums will increase, and fewer issuers may participate in a state's marketplace. This could lead to market segmentation that "could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage."[9]

Conclusion

The Society represents people with MS, as well as their family and professional caregivers in urging protections for those living with the disease who need access to quality and affordable healthcare regardless of their income or geographic location. Given the history of AHPs, we are deeply concerned that this legislation could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law – and put those we represent at risk.

We urge the committee not to pass HB 5383 and to protect Connecticut residents. Should you have any questions or concerns, please feel free to reach out to Laura Hoch at laura.hoch@nmss.org or (860) 913-2550 X52521.

[9] American Academy of Actuaries, "Issue Brief: Association Health Plans", Feb. 2017, available at http://www.actuary.org/content/association-health-plans-0.